Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Springfield Insurance Enrollment Form – Active Employees and Non-Medicare Retirees

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		/ /	666/

Name - Last | First | MI

Address | City | State | Zip Code

Home Phone ( ) | Work Phone ( )

02 ☐ **HEALTH COVERAGE** | **Effective Date: 01/ 01 /2007**

New Enrollment ☐ | **Decline Coverage** ☐

☐ **Health** (Select one of the health plans below and individual or family coverage)

Health Plan – Active Employees and Non-Medicare Retirees

☐ **Commonwealth Indemnity Plan Basic** CIC: ☐Yes ☐ No

☐ **Commonwealth Indemnity Plan Community Choice** ☐ **Harvard Pilgrim Independence Plan** ☐ **Navigator by Tufts Health Plan**

☐ **Commonwealth Indemnity Plan PLUS** ☐ **HMO:** _____

(Write in the name of the HMO and complete the HMO Enrollment Application and send it to the Plan.)

Coverage
☐ **Individual**
☐ **Family**

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse, who will be covered under your family plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for all children ends at age 19, except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. You are required to complete a student or handicapped application for any dependent you are listing below who is age 19 or over. Attach separate sheet if additional space is required.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective date: _____

SPOUSE INFORMATION

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number_____ Address of insurance company_____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number_____

FORMER SPOUSE

Name _____Social Security Number _____ Date of Birth _____ Date of Divorce _____

Last First Middle

Address _____

Street City State Zip Code

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

SIGNATURE REQUIRED

x _____ Signature of Applicant Date

x _____ Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision